PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, January 28, 2003, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Chair Christine Ferguson, Mr. Manthala George, Jr., Mr. Albert Sherman, Ms. Janet Slemenda, Dr. Thomas Sterne, and Dr. Martin Williams. Ms. Phyllis Cudmore, Ms. Shane Kearney Masaschi, and Ms. Maureen Pompeo absent. Also in attendance was Attorney Donna Levin, General Counsel.

Chairwoman Christine Ferguson announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½. NEW BUSINESS: Staff Presentation: "Women's Health in Massachusetts: Highlights from the Behavioral Risk Factor Survey", by Sally Fogerty, Assistant Commissioner, Bureau of Family and Community Health and Dr. Bruce Cohen, Director, Division of Research and Epidemiology, Bureau of Health Statistics, Research and Evaluation.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Bruce Cohen, Director, Division of Research and Epidemiology, Ms. Sally Fogerty, Assistant Commissioner, Bureau of Family and Community Health, Ms. Gillian A. Haney, Surveillance Program Manager, Division of Epidemiology and Immunization; Dr. Paul Dreyer, Director, Division of Health Care Quality; Mr. Jere Page, Senior Analyst, and Ms. Joyce James, Director, Determination of Need Program.

PERSONNEL ACTIONS:

In letters dated January 9, 2003, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointment and reappointments to the various medical staff of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associated Executive Director for Medicine of Tewskbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointment and reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning January 1, 2003 to January 1, 2005:

APPOINTMENT:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Adam Hauser, M.D.	Provisional/Affiliate Psychiatry	211664

REAPPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Krissie Connor, DO	Affiliate	207984
Debra DeFlumeri, RNC	Allied	160537
Victoria Knowlton, RNC	Allied	131213
Jean O'Farrell, RNC	Allied	145299
R.James Stratton, RNC	Allied	117192
Ann Teele, PhD	Allied	1360
Thomas Martin, PhD	Allied	2122
Steve Nisenbaum, JD, PHD	Allied	3670

In a letter dated January 13, 2003, Paul D. Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of initial appointments and reappointments to the medical and allied health professional staffs of Lemuel Shattuck Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) : That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the initial appointments and reappointments to the various medical staffs and allied health professional of Lemuel Shattuck Hospital be approved as follows:

APPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Bruce Kaster, M.D.	Active/Psychiatry	76271
Anne LaRaia, M.D.	Consultant/Internal Medicine	215652
Andrew Lipman, M.D.	Consultant/Internal Medicine	216325
M. Elizabeth Weidmer-Mikhail, M.D.	Active /Psychiatry	205356
Tommy Seller, M.D.	Active/Psychiatry	38087
Stephen Naber, M.D.	Active/Pathology	59990

REAPPOINTMENTS:

Harriet Scheft, M.D.	Active/Psychiatry	78086
Joel Perlman, D.M.D.	Consultant/Dentistry	12623
Scott Shikora, M.D.	Consultant/General Surgery	57931

ALLIED HEALTH PROFESSIONALS:

Patricia Clifford, P.A.	Allied Health Professional	#211

In letters dated January 7, 2003 and January 13, 2003, Blake M. Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of an appointment and reappointment to the consulting medical staff of Western Massachusetts Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendations. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointment and reappointment to the consulting medical staff of Western Massachusetts Hospital be approved:

APPOINTMENTS:	**RESPONSIBILITY:**	**LICENSE NO.:**
Denise Barresi, DMD	Dentistry	20699
RE-APPOINTMENT:	**RESPONSIBILITY:**	**LICENSE NO.:**
Juliette Ochola, DDS	Dentistry/Oral Surgery	19020

STAFF PRESENTATION:

WOMEN'S HEALTH IN MASSACHUSETTS: HIGHLIGHTS FROM THE BEHAVIORAL RISK FACTOR SURVEY", BY MS. SALLY FOGERTY, ASSISTANT COMMISSIONER, BUREAU OF FAMILY AND COMMUNITY HEALTH AND DR. BRUCE COHEN, DIRECTOR, DIVISION OF RESEARCH AND EPIDEMIOLOGY, BUREAU OF HEALTH STATISTICS, RESEARCH AND EVALUATION:

Dr. Bruce Cohen, Director, Division of Research and Epidemiology, said in part, "Mammography has been a success story in Massachusetts. The overall rates are above the U.S. average, 84 percent compared to 81 percent, and women in all race groups are using this important screening tool. Not only are mammography rates higher for all race groups, but the overall rate is continuing to climb. From 1992 to 2000, the mammography rate for women age forty and above has gone up 24 percent, from 68 percent to 84 percent. The Massachusetts rate continues to be higher than the U.S. rate. While there have been increases in breast cancer screening, there has been a concomitant decline in breast cancer mortality in Massachusetts. From 1996 to 2000, there has been a 15 percent decline in the age adjusted breast cancer mortality rate among Massachusetts women. Overall, Massachusetts women are more likely to have clinical breast exams than women nationwide, 86 percent compared to 79 percent. However, some racial disparities exist. Hispanic women are less likely and Asian women much less likely to report having a clinical breast exam in the past two years.…"

Dr. Cohen continued, "…In the last five years, one out of two, that is 50 percent, of the pregnancies to women who lived in households with incomes under twenty-five thousand dollars were unplanned, compared to about one out of eight pregnancies to women who lived in households with incomes over seventy-five thousand dollars….In the last year, one in twenty-five Massachusetts women report that they have experienced intimate partner abuse. That is 4 percent. There are dramatic differences by income with lower income women much more likely to report experiencing intimate partner abuse. Among women whose household income was less than twenty-five thousand dollars, one in ten women report experiencing partner abuse in the past year. The pattern is dramatic by race, as well, with Black and Hispanic women reporting more partner abuse than White women. Women from households with the lowest income were 33 percent more likely to report having been sexually assaulted in their lifetime. That is 32 percent compared to 24 percent. Almost one in four of adult Massachusetts women age eighteen to fifty-nine reported having experienced sexual assault at some time during their lives, 23 percent of the overall figure. Women in the Commonwealth are quite healthy compared to women nationwide. Massachusetts women have the second highest clinical breast examination rate, the third highest mammography rate, and the third highest rate of Pap tests. Despite enormous race variations, Massachusetts women had the second lowest obesity rate, the ninth lowest smoking rate, the third highest rate of fruit and vegetable consumption, and the tenth highest rate of physical activity. Unfortunately, we do not have national data for partner abuse, sexual assault, birth control, and unplanned pregnancy. These are questions that were designed here at MDPH, and added to meet the needs for information that we have, and are not asked by all states."

Dr. Cohen concluded, "In summary, there are similarities and differences in health status between men and women in Massachusetts. Women are more likely to report poor health status, asthma and arthritis. Black and Hispanic women are more likely to be obese than white women. Massachusetts women are healthier than U.S. women on many indicators. Among women in Massachusetts, preventative services and health practices vary by race, income and education, and age. The use of mammography has increased 24 percent from 1992 to 2000, and is high for women in all age groups. Asian women are less likely to have Pap test or clinical breast exam. Black, Asian and Hispanic women are less likely to report using birth control. And women from low income families are more likely to report experiencing intimate partner abuse and sexual assault. In conclusion, we have a lot to celebrate about women's health in Massachusetts. The health of women in the Commonwealth is well above the average on many indicators but there still is much to do. Substantial disparities in health status do continue to exist by race, ethnicity and socioeconomic status. This report does not focus on other interconnected issues for women, such as reproductive health, infectious disease and access to care, and many of the issues raised are important for men, as well as for women. Nevertheless, it is clear as women live longer, the impact of chronic disease is increasing. Violence towards women is a major concern, and timely use of preventive services needs to be constantly reinforced…."

REGULATIONS:

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 300.000: REPORTABLE DISEASES AND ISOLATION AND QUARANTINE REQUIREMENTS, AND 105 CMR 365.000: STANDARDS FOR MANAGEMENT OF TUBERCULOSIS OUTSIDE HOSPITALS:

Ms. Gillian Haney, Director of Surveillance for Division of Epidemiology and Immunization, presented the Request for Final Promulgation of Amendments to 105 CMR 300.000, Reportable Diseases and Isolation and Quarantine Requirements, and 105 CMR 365.000, Standards for Management of Tuberculosis Outside Hospitals. Ms. Haney began, "…The request for final promulgation of amendments to 105 CMR 300.000 and 105 CMR 365.000 is a culmination of two and a half years work by the Department and its public health partners. The first time these regulations were comprehensively updated was in 1992, and an HIV AIDS specific modification occurred in 1998. These regulations have been comprehensively updated to incorporate new federal communicable disease surveillance recommendations and the latest recommendations for isolation and quarantine. The Department established an advisory committee in September of 2000 to assist with the content revision of these regulations. This committee was comprised of representatives from local boards of health, professional organizations and other public health professionals. The Department held two public hearings in December 2002…Two individuals offered oral testimony, totaling forty-seven individual comments. The Department responded to all comments, which were submitted in memorandum before this Council and made provisions to the regulation accordingly."

"In summary, the following four core revisions are proposed. To reflect emerging infectious disease threats, changes in nomenclature and newly recognized disease surveillance presentations, certain disease or conditions were added to the list of those diseases reportable to local boards of health or further clarification of the reportable event was provided. There will be approximately seventy-five diseases or events listed, of which seventeen are new additions. A new section maintaining the confidentiality of health related records was also added, the reporting of significant diseases occurring in animals that may have the potential to affect humans. To address issues around emerging infectious disease threats of bioterrorism, a new section was added, granting the Commissioner the authority to order the immediate reporting of any emerging infectious disease which threatens public health. Invoking this clause shall be on a time limited basis for a period not to exceed twelve months. Laboratory reporting, which has been under regulations for the past years, has been formalized by specifying a list of organisms that are reportable directly to the Department; and, we formalized a request that specific antibiotic resistance patterns be also reported. A new section clarifying specific actions necessary to the investigation, control and prevention of diseases that may be taken by the Department and local boards of health was added. The final proposed change to the regulations involves updating the recommendations for isolation and quarantine based on the latest recommendations of national advisory bodies and agencies, including the Federal Centers for Disease Control and Prevention…"

After consideration upon motion made and duly seconded, it was voted: (unanimously) **to approve the Request for Final Promulgation of Amendments to 105 CMR 300.000: Reportable Diseases and Isolation and Quarantine Requirements, and 105 CMR 365.000: Standards for Management of Tuberculosis Outside Hospitals**: That a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,749.** A public hearing had been held on December 12, 2002 at the State Laboratory Institute in Boston, MA and on December 17, 2002 at the Western Massachusetts Regional Office in Northampton, MA.

REQUEST FOR EMERGENCY AMENDMENT TO DETERMINATION OF NEED REGULATIONS 105 CMR 100.000 GOVERNING APPLICATION FILING DATES FOR INNOVATIVE SERVICES AND NEW TECHNOLOGY:

Dr. Paul Dreyer, Director, Division of Health Care Quality, said, "I am here today to request emergency promulgation of amendments to the DoN regulations that would move the filing date for neonatal intensive care unit beds, which are among the suite of innovative services/ from the first business day of February 2003 to the first business day of August 2003. By way of background the Council adopted revisions to the guidelines for NICU services last July, which showed a need for twenty-five beds, and subsequently approved a ten bed unit at South Shore Hospital under these guidelines last November. Following the promulgation of the guidelines, the perinatal community began an intensive discussion as to the best way to address the need for neonatal intensive care unit beds. Discussions are currently underway that may result in strategies that address bed shortage issues in ways that are less expensive than the development of new neonatal intensive care units. The emergency promulgation that we are proposing will allow time for these discussions to come to fruition. We therefore request the Council's approval of this proposed amendment."

After consideration, upon motion made and duly seconded, it was voted unanimously: That, the Request for Emergency Amendment to Determination of Need Regulations 105 CMR 100.000 Governing Application Filing Dates for Innovative Services and New Technology, be approved; that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the regulation be attached to and made a part of this record as **Exhibit Number 14,750.**

DETERMINATION OF NEED PROGRAM: CATEGORY 1 APPLICATION:

PROJECT APPLICATION NO. 5-1440 OF ROYAL MEGANSETT NURSING AND RETIREMENT HOME FOR NEW CONSTRUCTION OF A THIRD FLOOR ADDITION TO REPLACE 30 LEVEL III BEDS OF THE 90-BED LEVEL III AND LEVEL IV FACILITY, AND SUBSTANTIAL RENOVATION TO UPGRADE MAJOR BUILDING COMPONENT SYSTEMS AND EXPAND EXISTING SINGLE BEDROOMS TO SEMI-PRIVATE ROOMS:

Mr. Jere Page, Senior Analyst, Determination of Need Program, said, "Royal Megansett is here before the Council seeking approval for new construction to replace thirty Level III existing beds in a third floor addition to the existing ninety bed Royal Megansett Nursing Home in North Falmouth. The project also involves substantial renovation to upgrade the major building components and expand existing resident single bedrooms to semi-private rooms. The new construction and renovation is designed to correct a number of physical plant deficiencies that can no longer be adequately addressed by adjustments in procedures and operations. The recommended capital expenditure is just over three million dollars…It reflects new construction and renovation costs, which would be less than allowed under our standard Marshall & Swift Valuation Service calculations. J&B Partnership, which is the parent, also has ownership interest in three other nursing homes in Massachusetts….We are recommending approval of this project with the conditions listed in the staff summary. The conditions included, among others, the applicant establish a plan to protect the privacy, health and safety of the facility residents during the construction process."

After consideration, upon motion made and duly seconded, it was voted: (unanimously) to **approve Project Application No. 5-1440 of Royal Megansett Nursing & Retirement Home for new construction to replace 30 Level III beds in a third floor addition of the existing facility. The project also includes substantial renovation to upgrade the existing HVAC, plumbing, sprinkler and electric systems, add a new elevator and elevator vestibule and expand existing resident single bedrooms to semi-private rooms. A summary is attached to and made apart of this record as Exhibit Number 14,751),** based on staff findings with a maximum capital expenditure of $3,387,705 (January 2002 dollars) and first year incremental operating costs of $288,105 (January 2002 dollars). This Determination is subject to the following conditions:

1. The applicant shall accept the maximum capital expenditure of $3,387,705 (January 2002 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.
2. The total approved gross square feet (GSF) for this project is 23,650 GSF: 9,923 GSF for new construction to replace 30 Level III beds in a 3rd floor addition; and 13,727 GSF for substantial renovation to upgrade the existing HVAC, plumbing, sprinkler and electrical systems, add a new elevator and elevator vestibule and expand resident single bedrooms to semi-private rooms.

3. The applicant shall, prior to construction, sign a formal affiliation agreement with at least one local acute care hospital and one local home care corporation that addresses provision for respite services.
4. The applicant shall establish a plan to protect the privacy, health and safety of the residents of the facility during the construction process.
5. Upon implementation of the project, any assets such as land, building improvements, or equipment which are either destroyed or no longer used for patient care, shall not be claimed for reimbursement for publicly aided patients.
6. The Department shall reserve the right to conduct a review of the financial feasibility of the project based on the Division of Health Care Finance and Policy's established rates of reimbursement for Medicaid patients at the time final maximum capital expenditures or any adjustments to the final maximum capital expenditures are submitted to the Determination of Need Program for approval in the event that such expenditures exceed the approved maximum capital expenditure. The applicant shall submit a revised Factor Six (Financial Schedules) upon request by the Department. The applicant is advised that an increase in equity may be necessary to assure the financial feasibility of the project.

Staff's recommendations was based on the following findings:

1. The applicant proposes construction and substantial renovation at the existing 90-bed facility. The new construction will replace 30 Level III beds in a third floor addition, and the renovation will upgrade the existing buildin g component systems, including the HVAC, plumbing, sprinkler, and electrical systems, as well as add a new elevator and elevator vestibule and expand existing single bedrooms to semi-private rooms.
2. The health planning process for this project is satisfactory.
3. Consistent with Determination of Need Guidelines for Nursing Facility Replacement and Renovation (Guidelines), the applicant has demonstrated need for new construction to replace 30 existing Level III beds, and substantial renovation to upgrade the existing building component systems, add a new elevator and elevator vestibule and expand existing resident single bedrooms to semi-private rooms.
4. The project, with adherence to certain conditions, meets the operational objectives factor of the Guidelines.
5. The project, with adherence to a certain condition, meets the standard compliance factor of the Guidelines.
6. The recommended maximum capital expenditure of $3,387,705 (January 2002 dollars) is reasonable compared to similar, previously approved projects.
7. The recommend ed incremental operating costs of $288,105 (January 2002 dollars) are reasonable based on similar, previously approved projects. All operating costs are subject to review by the Division of Health Care Finance and Policy and third party payors according to their policies and procedures.
8. The project is financially feasible and within the financial capability of the applicant.
9. The project meets the relative merit requirements of the Guidelines.
10. The Division of Health Care Finance and Policy submitted comments related to the financial feasibility of the project.
11. The project is exempt from the community health initiatives requirement.

12. The Andrew Daly Ten Taxpayer Group (TTG) registered in connection with the project, but did not request a public hearing. The TTG also waived in writing the 21-day send-out for the staff summary to the Public Health Council.

The meeting adjourned at 10:50 a.m.

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Christine C. Ferguson, Chair
Public Health Council

LMH/SB